

**INSURANCE INFORMATION-Please present your insurance cards at time of appointment.**

**PRIMARY INSURANCE NAME** \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_

INSURANCE ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

NAME OF PERSON WHO CARRIES INSURANCE: \_\_\_\_\_  
(NAME ON INSURANCE CARD) LAST FIRST MI

SSN \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ SEX \_\_\_ Male \_\_\_ Female

BIRTHDATE \_\_\_\_\_ STUDENT STATUS \_\_\_ Full-Time \_\_\_ Part-Time

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE (\_\_\_\_) \_\_\_\_\_ WORK PHONE (\_\_\_\_) \_\_\_\_\_

**NAME OF PERSON WHO CARRIES INSURANCE: EMPLOYMENT INFORMATION**

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE (\_\_\_\_) \_\_\_\_\_ HIRE DATE \_\_\_\_\_ OCCUPATION \_\_\_\_\_

STATUS \_\_\_ Full-Time \_\_\_ Part-Time \_\_\_ Retired \_\_\_ Active Military  
\_\_\_ Unemployed \_\_\_ Self-Employed \_\_\_ Disabled

EFFECTIVE DATE \_\_\_\_\_ GROUP # \_\_\_\_\_

CERTIFICATE / POLICY # \_\_\_\_\_

RELATIONSHIP OF PATIENT TO PERSON WHO CARRIES INSURANCE:

PAYOR ID # \_\_\_\_\_

\_\_\_ Self \_\_\_ Husband \_\_\_ Wife  
\_\_\_ Son \_\_\_ Daughter \_\_\_ Other

Is this coverage: \_\_\_ Group (usually provided through employment) \_\_\_ Individual Insurance Co-Pay Amount \_\_\_\_\_

**SECONDARY INSURANCE NAME** \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_

INSURANCE ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

NAME OF PERSON WHO CARRIES THE INSURANCE: \_\_\_\_\_  
LAST FIRST MI

SSN \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ SEX \_\_\_ Male \_\_\_ Female

BIRTHDATE \_\_\_\_\_ STUDENT STATUS \_\_\_ Full-Time \_\_\_ Part-Time

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE (\_\_\_\_) \_\_\_\_\_ WORK PHONE (\_\_\_\_) \_\_\_\_\_

EFFECTIVE DATE \_\_\_\_\_ GROUP # \_\_\_\_\_

CERTIFICATE / POLICY # \_\_\_\_\_

RELATIONSHIP OF PATIENT TO PERSON WHO CARRIES INSURANCE:

PAYOR ID # \_\_\_\_\_

\_\_\_ Self \_\_\_ Husband \_\_\_ Wife  
\_\_\_ Son \_\_\_ Daughter \_\_\_ Other

Is this coverage: \_\_\_ Group(usually provided through employment) \_\_\_ Individual

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

If this visit is related to a JOB INJURY or AUTO ACCIDENT, please inform the receptionist as there is additional paperwork to complete.